

Medical Records Release Form

If you would like your records transferred to Ashburn Family Healthcare, please complete this form:

Patient Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone: _____

By signing this form, I authorize:

Phone/ Fax: _____

to release protected health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to:

Neeta Goel, MD
Daniel Abeel, PA-C
Ashburn Family Healthcare
20600 Gordon Park Square, Suite 130
Ashburn, VA 20147
Tel: (703) 723-3110 Fax: (703) 723-0115

The purpose of this disclosure is: _____

The information you may release subject to this signed release form is as follows:

Lab/Pathology Reports Radiology Reports Hospital Reports
 Treatment Records Operative Reports **All Records**
 Other _____

I authorize the use and disclosure of information in my medical record relating to:

(Initial in space provided) Psychiatric/Mental Health Substance Abuse
 STDs/HIV/AIDS Pregnancy/Contraception

Unless otherwise revoked, this authorization will expire on _____ or in **six months**.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so by presenting my written revocation to Ashburn Family Healthcare. The revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, and I need not sign this form in order to assure treatment. I may inspect the information to be used or disclosed, as provided in CFR 164.524. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules (Information disclosed regarding treatment for alcohol and/or drug abuse is protected by Federal law. Federal regulations (Title 43 CFR Part 2) prohibit anyone from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations).

I understand that if I have questions about HIPAA Privacy Rule or the disclosure of my protected health information, I can contact the AFH Privacy Officer at (703) 723-3110.

Signature of Patient or Legal Guardian

Relationship to Patient

Date